CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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INTRODUCTION

Hospice care under the Virginia Medicaid Program must not be of any less or greater duration, scope, or quality than that provided recipients not receiving State and/or federal assistance.

To be covered, hospice services must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions. The individual must be certified as being terminally ill and must elect hospice coverage. A plan of care must be established, and the services must be consistent with the plan of care.

Hospice means an autonomous, centrally-administered, medically directed program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill recipient and his or her family. It employs an interdisciplinary team to assist in providing palliative care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and during bereavement. The hospice approach utilizes volunteers and family members and trains them to provide much of the patient care. This unique combination of professional and voluntary staff and family members ensures a greater magnitude of services which can be provided to sustain the highest possible quality of life. The hospice goal is to maintain the individual at home for as long as possible while providing the best care available to the recipient thus avoiding institutionalization whenever possible.

ADMISSION CRITERIA FOR COVERED HOSPICE SERVICES

To be eligible to elect hospice care under Medicaid, an individual must be certified as terminally ill. An individual is considered to be terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less if the terminal illness runs its normal course. In addition, the individual or, in cases where a representative has signed the election statement, his or her representative, must have knowledge of the illness and life expectancy and must elect to receive hospice services rather than active treatment for the illness. Both the attending physician and the hospice medical director or physician member of the interdisciplinary team must certify the life expectancy. Hospice benefit periods begin with the date of the recipient/caregiver signature.

The hospice must obtain the certification that an individual is terminally ill in accordance with the following procedures:

a. For the initial 90-day benefit period of hospice coverage, a Medicaid written certification (DMAS 420) must be signed and dated by the medical director of the hospice and the attending physician or the physician member of the hospice interdisciplinary team and the attending physician, at the beginning of the certification period. This initial certification must be obtained prior to the request for preauthorization. This certification must be recorded on the Request for Hospice Benefits form (DMAS 420).

b. For any subsequent 90-day or 60-day hospice period, a Medicaid written certification (DMAS 420) must be signed and dated by the medical director of the hospice or the physician member of the hospice's interdisciplinary team before or on the beginning day of the 90-day or 60-day hospice period. This certification must include the statement that the recipient's medical prognosis is that his or her life expectancy is six months or less. This certification must be maintained in the recipient's medical record.

c. In cases of retroactive eligibility, the requirements listed above still apply.

FREEDOM OF CHOICE

Medicaid eligible individuals must be offered the choice of service provider(s). The individual's choice of providers is a federal requirement. Freedom of choice must be documented in the individual file of the recipient.

ELECTION OF HOSPICE CARE

The election of the hospice benefit is the recipient's choice rather than the hospice's choice. The hospice benefit is not designed to meet the needs of every terminally ill individual. The recipient and his or her family must be fully informed of the services available and any limitation on those services prior to electing the benefit. Some individuals' needs can be more effectively met by utilizing other state and/or local programs and services.

Hospice benefits are a carved out service of Medicaid Health Maintenance Organizations (HMOs). Therefore, once a recipient elects hospice benefits, it is important for the hospice provider to submit the necessary documentation in order for the recipient to be disenrolled from participation in the HMO program.

The hospice care benefit consists of two 90-day periods, followed by an unlimited number of 60-day periods (referred to as election periods). An individual must elect to receive hospice care in order to receive hospice services. A Request for Hospice Benefits form (see "EXHIBITS" at the end of Chapter VI for a sample of this form) must be completed by the individual or the individual's representative who is, because of the individual's mental or physical incapacity, authorized in accordance with State law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill individual. When an individual elects Medicaid hospice care, he or she waives rights to services covered by Medicaid, which are also covered by the Medicare Program. Therefore, after the hospice election, Medicaid payment would still be made for services covered under the Virginia *State Plan for Medical Assistance* if those services are not covered by Medicare and the recipient meets the criteria for that program.

This does not mean, however, that a hospice provider may provide less services than specified in the *Code of Federal Regulations*, Title 42, Part 418, simply because the services could also be covered under another Medicaid benefit. For example, since payment to the hospice includes home health aide services, a hospice provider cannot

refuse to provide these services because similar services are available under another

benefit. In addition, DMAS will reimburse the hospice only for services which are medically necessary. Services which are duplicative would be considered unnecessary. A hospice recipient may be considered appropriate for personal care services if the services cannot be provided under the law by home health aide or homemaker services.

DMAS prior authorization is required for reimbursement to be made for simultaneous provision of services under the hospice Medicare or Medicaid benefit and any Medicaid-covered waiver program.

Hospice care may not be provided by a hospice other than the hospice designated by the individual unless services are provided under arrangements made by the designated hospice. Any Medicaid services related to the treatment of the terminal condition for which hospice care was elected are waived except for services provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

Nursing facilities under contract with Medicaid to provide specialized care are required to provide all services, equipment, and supplies necessary to carry out the plan of care ordered by the physician. Therefore, Medicaid will not authorize any payment to the hospice for a recipient participating in specialized care. The nursing facility is required to coordinate any necessary services.

An election period to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care, as long as the individual remains in the care of the hospice and does not revoke the election in writing.

The election statement must include the following:

- Identification of the particular hospice that will provide care to the individual;
- The individual's (or representative's) acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to his or her terminal illness;
- Acknowledgment that certain Medicaid services are waived by the election of hospice care;
- The effective date of the election; and
- The signature and date of the individual or representative.

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If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected and revoked simultaneously under both programs.

Authorization to bill for Medicaid hospice services does not guarantee Medicaid payment for these services. The following conditions must be met for payment to be made:

- The recipient must be eligible for Medicaid during the dates of service delivery;
- The recipient must not have revoked the hospice election;
- The hospice provider must be enrolled with Medicaid during the dates of service delivery; and
- The hospice provider must pursue all other payment sources (e.g., Medicare and other insurance) prior to submitting a claim to DMAS.

DMAS reimbursement is subject to all DMAS utilization review activities.

REVOCATION OF HOSPICE SERVICES

An individual (or representative) may revoke the election of hospice care at any time during an election period using the Hospice Benefits Change/Revocation form (see "EXHIBITS" at the end of Chapter VI for a sample of this form). Upon revocation of the election of Medicaid coverage of hospice care, the individual is no longer covered by Medicaid for hospice care but, if eligible, may resume Medicaid coverage under the regular scope of benefits. The individual may at any time elect to receive hospice coverage for any other benefit period(s) that he or she is still eligible to receive. The hospice must notify DMAS of the revocation within five days following the revocation and include an explanation of the reason for the revocation.

A recipient who elected hospice prior to January 1, 1999, and who may be discharged from hospice care at some future time because he or she is no longer terminally ill could avail himself or herself of the benefit at some later date if he or she should become terminally ill again and otherwise meet the requirements of the Medicaid hospice benefit. If the recipient had been discharged or revoked during the initial 90-day period, he or she would enter the benefit in the second 90-day period. If the discharge or revocation took place during the final 90-day or any subsequent 60-day period, the recipient would enter the benefit in a new 60-day period. A recipient who had been discharged from hospice during the fourth benefit period prior to January 1, 1999, would be eligible for the benefit again and would begin it in a 60-day period. The 90-day periods would not be available as the benefit still only provides for two 90-day periods during an individual's lifetime. There is no limit on 60-day periods as long as the recipient meets the requirements for the hospice benefit.

CHANGE OF HOSPICE PROVIDER

An individual (or representative) may change the designation of the particular hospice from

which the hospice care will be received once in each election period by using the Hospice Benefits Change/Revocation form (see "EXHIBITS" at the end of Chapter VI for a sample of the form).

The change of the designated hospice is not a revocation of the election period for which it is made. However, the new hospice provider must complete an election form when a change is made.

NOTIFICATION OF DEATH

The hospice agency must notify DMAS of the death of a recipient no later than five days following the death. The local Department of Social Services which has case responsibility for the recipient must also be notified.

CATEGORIES OF CARE

As described for Medicare and applicable to Medicaid, hospice services entail the following four categories of daily care:

a. Routine home care is at-home care that is not continuous.

b. Continuous home care consists of at-home care that is predominantly nursing care and is provided as short-term crisis care. A registered nurse or licensed practical nurse must provide care for more than half of the period of care. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home care.

c. Inpatient respite care is short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver(s) providing at-home care for the recipient. No more than five consecutive days of respite care will be allowed.

d. General inpatient care may be provided in an approved freestanding hospice, hospital, or nursing facility. This care is usually for pain control or acute or chronic symptom management which cannot be successfully treated in another setting.

GENERAL HOSPICE SERVICES

A hospice must ensure that substantially all of the core services (physician, nursing care, social work , and counseling) are routinely provided directly by hospice employees to the recipient. A recipient or designated representative may refuse home health aides or homemaker services, social work, or counseling services, but the reason must be clearly documented in the medical record and identified in the plan of care. If appropriate when due to a change in the recipient's needs, it should be re-introduced to the recipient/ responsible party and the results of this discussion identified in the plan of care.

A hospice may use contracted home health aides or homemaker services, if necessary, to supplement hospice employees to meet the needs of the recipients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice must maintain professional, financial, and administrative responsibility for the services and assure that the qualifications of staff and services provided meet all of the requirements. Documentation must be maintained by the provider to ensure that the contracted aide has been fully trained in hospice philosophy and the provision of palliative care prior to any recipient contract. The hospice maintains responsibility of the nursing supervisory visits of any contracted aide.

As a temporary measure, from October 1, 2002, through September 2004, an individual hospice provider may contract with another agency to provide registered nurse case managers, if the hospice can demonstrate that the nursing shortage constitutes an extraordinary circumstance that prevents it from hiring an adequate number of nurses directly. This "extraordinary circumstance" exemption must be approved by the state agency responsible for licensing and certification. Any hospice contracting a registered nurse under this measure must ensure that the nurse has been fully trained in the hospice philosophy and the provision of palliative care prior to any patient contact.

The hospice is required to have a legally binding written agreement for the provision of such arranged services as x-ray, laboratory, and pharmaceutical services for Medicaid-eligible hospice recipients. The hospice retains financial responsibility for these services. Although the services are provided to a Medicaid recipient, since the hospice retains financial responsibility, there is no obligation on the part of the service provider to accept the Medicaid-allowable payment on the basis of the recipient's eligibility status. Provision of and payment for these services should be included in the contractual agreement between the hospice and the service provider.

All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

a. **Nursing Care** - Nursing care must be provided by a registered nurse who is licensed by the Board of Nursing of the Commonwealth of Virginia or the state in which the hospice provider is located or by a licensed practical nurse under the supervision of a licensed registered nurse who is a graduate of an approved school of professional nursing. Nursing services must be directed and staffed to assure that the nursing needs of recipients are met. Patient care responsibilities of nursing personnel must be specified. Services must be provided in accordance with recognized standards of practice.

b. **Home Health Aide and Homemaker Services** - Home health aides must meet the qualifications specified for home health aides by federal and state criteria. Home health aide and homemaker services must be available and adequate to meet the needs of the recipients. Home health aides may provide personal care services. Aides may also perform household services to maintain a safe and sanitary environment in areas of the home used by the recipient, such as changing the bed or light cleaning and laundering essential to the comfort and

cleanliness of the recipient. Homemaker services may include assistance in personal care, maintenance of a safe and healthy environment, and services to enable the individual to carry out the plan of care. Home health aide and homemaker services must be provided under the general supervision of a registered nurse. A registered nurse must visit the home site at least every two weeks when aide services are being provided, and the visit must include an assessment of the aide services. Written instructions for patient care are prepared by a registered nurse. The hospice provider must cover at least 21 hours per week of homemaker/home health aide services for any person who requires those services. Personal care under the Elderly and Disabled Waiver will not be available to the hospice recipient unless the hospice can document the provision of at least 21 hours per week of homemaker/home health aide services and that the recipient needs personal care-type services which exceed this amount. If at the time of the hospice assessment, the recipient's needs reflect that more than 21 hours per week are needed, and these needs cannot be met by hospice staff, volunteers, the family, or other community resources, the hospice will evaluate if the recipient meets the criteria for the personal care program. A maximum of 38.5 hours per week of personal care can be provided and then only if the hospice is providing a minimum of 21 hours of homemaker/home health aide services per week. The hospice must coordinate with the personal care provider to establish and agree upon one plan of care for both providers. Once a recipient is accepted for care, the hospice may not discharge the recipient at its discretion even if the recipient's care becomes costly or inconvenient. If the recipient's assessed needs for homemaker/home health aid care are in excess of 59.5 hours per week (which may be provided with combined services of hospice and personal care), the hospice is responsible for meeting the needs.

If a recipient is under the hospice benefit and it is determined that he needs additional aide services through the personal care program, the hospice provider is responsible for coordination of all needed services. The hospice and personal care providers must develop a plan of treatment that will meet the needs of the recipient.

If a personal care recipient elects the hospice benefit, the hospice provider then becomes the coordinator of all needed services. The hospice and personal care providers must develop a plan of treatment that will meet the needs of the recipient.

c. **Medical Social Services** - Medical social services must be provided by a social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education and who is working under the direction of a physician.

d. **Physician Services** - Physician services must be performed by a professional who is legally authorized to practice, who is acting within the scope of his or her license, and who is a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor. The hospice medical director or the physician member of the interdisciplinary team must be a licensed doctor of medicine or osteopathy.

Attending physician means a physician who is a doctor of medicine or osteopathy and is identified by the individual or representative, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

e. **Counseling Services** - Counseling services must be provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual's family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual's approaching death.

Bereavement counseling consists of counseling services provided to the individual's family up to one year after the individual's death. "Family" means the recipient's immediate kin, including a spouse, brother, sister, child, or parent or any other relation or individual with significant personal ties to the recipient who, by mutual agreement with the recipient, the family, and the hospice, participates in the patient's care. The plan of care for bereavement counseling should reflect family needs, as well as a clear delineation of services to be provided and the frequency of service delivery.

Dietary counseling, when required, must be provided by a qualified professional and described in the plan of care. Spiritual counseling must include notice to the recipient as to the availability of clergy. Other counseling services may be provided by other members of the interdisciplinary team as well as by other qualified professionals as determined by the hospice.

Counseling services are required by federal mandate to be provided as part of the "core services" of the hospice program. Medicaid will not provide direct reimbursement to the hospice or any other provider for counseling services provided.

f. **Short-Term Inpatient Care** - Short-term inpatient care may be provided in a participating Medicaid hospice inpatient unit, or a participating Medicaid hospital or nursing facility. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings.

Inpatient care may also be furnished to provide respite for the individual's family or other persons caring for the individual at home. Respite care means short-term inpatient care provided in an approved facility (freestanding hospice, hospital, or nursing facility) to relieve the primary caregiver(s) providing at-home care for the recipient. No more than five consecutive days of respite care will be covered.

Hospice recipients are exempted from the preadmission screening for nursing facility requirements. However, the above criteria must be met for inpatient hospital stays.

g. **Durable Medical Equipment and Supplies** - Durable medical equipment as well as other self-help and personal comfort items related to the palliation or management of the recipient's terminal illness are covered. Medical supplies include those supplies that are part of the written plan of care. Medical supplies and appliances must be provided as needed for the palliation and management of the terminal illness and related conditions.

h. **Drugs and Biologicals** - Only drugs used primarily for the relief of pain and symptom control related to the individual's terminal illness are covered. All drugs and biologicals must be administered in accordance with accepted standards of practice. The hospice must have a policy for the disposal of controlled drugs maintained in the recipient's home when those drugs are no longer needed by the recipient. Drugs and biologicals must be provided as needed.

i. **Rehabilitation Services** - Rehabilitation services include physical and occupational therapies and speech-language pathology services that are used for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills. Rehabilitative services must be available, and when provided, offered in a manner consistent with

accepted

standards of practice.

Rehabilitative services shall be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable.

Occupational therapy services are covered only when performed by an occupational therapist registered and certified by the American Occupational Therapy Certification Board or an occupational therapy assistant certified by the American Occupational Therapy Board under the direct supervision of an occupational therapist as defined above.

Physical therapy services can only be performed by a physical therapist licensed by the Board of Medicine in the state in which the hospice is located or a physical therapy assistant who is licensed by the Board of Medicine and under the direct supervision of a physical therapist licensed by the Board of Medicine.

Speech-language therapy services can only be performed by a speech-language pathologist licensed by the Board of Audiology and Speech Pathology in the state in which the hospice provider is located.

For additional information on rehabilitation services, refer to the *Rehabilitation Manual* issued by DMAS.

AUTHORIZATION FOR SERVICES

Admission for hospice services must be preauthorized. If all preauthorization information is not provided, preauthorization requests will not be preauthorized and will be returned to the provider. Effective January 1, 2003, providers will be required to submit their preauthorization requests to the Department of Medical Assistance Services (DMAS) for any recipient requesting to elect their hospice benefit. The DMAS – 421A form (see the "Exhibits" at the end of Chapter VI for a sample of this form) is required to be faxed or mailed to DMAS to authorize these requests. Only the information requested on the form will be required. All requests for recipient enrollment to the hospice benefit must be received by DMAS within fourteen (14) days of the date of the physicians' signatures. DMAS will continue to conduct utilization reviews to ensure that services are appropriate and to validate the DMS-420, pages 1 and 2 as being completed and part of the medical record.

The DMAS-420, pages 1 and 2 must have all physician signatures and dates obtained within eight (8) days of the recipient's dated signature prior to the submission of the DMAS-421A to DMAS. If the required dated physician signature has not been obtained within this time frame, approval will begin on the date of the last physician's signature. If there is no date for either physician's signature, it is the hospice agency's responsibility to obtain current dated signatures certifying that the individual is eligible. Reimbursement will begin when a current signature and date are obtained. NOTE: Backdated signatures

are not acceptable.

Preauthorization will be requested by submitting the DMAS-421A (see the "Exhibits" at the end of Chapter of VI for a sample of this form) to:

Administrative Office Specialist
Facility and Home-Based Services Unit
Department of Medical Assistance Services
600 East Broad Street 10th, Suite 1300
Richmond, Virginia 23219

Phone: (804) 225-4222
Fax: (804) 371-4986

The following information must be completed by the provider for the recipient to be enrolled in the hospice program:

a. Recipient name;
b. Recipient Medicaid Number;
c. Provider enrollment information;
d. Hospice election date;
e. Hospice disenrollment date;
f. Acknowledgement of both physicians' signatures with dates.

Information must be printed and legible or it will be returned to the provider unprocessed. Forms that are not completed will also be returned. Requests for enrollment of patients that are not Medicaid approved at the time of their admission cannot be enrolled until they have an active Medicaid number; these forms are not to be faxed until the Medicaid number is available to the provider. After the provider preauthorization request is received by DMAS, the Administrative Office Specialist will enter it into the system and a blue letter will be generated via First Health.

In addition to the provision of core services (physician, nursing, medical social services, and counseling), all other covered services must be available and provided as needed to meet the needs of the recipient. When an individual elects Medicaid hospice care, he or she waives rights to services covered by Medicaid which are also covered by Medicare and which relate to the treatment of his or her terminal illness. Because the hospice is responsible for the provision of all covered services through one of four per diem rates, any covered services provided after the election of the hospice benefit become the financial responsibility of the hospice.

Note that a delay in enrollment shall place the hospice provider at risk of financial liability for covered services provided after the election statement is signed. Prompt enrollment limits the risk to the provider. DMAS will not enroll a recipient retroactively for those enrollment packages received more than 14 days from the date of the initial physician certification or recertifications, except in cases of actual retroactive eligibility. When enrollment packages or recertifications are received more than 14 days from the initial physician certification, enrollment will be effective the date DMAS receives the information.

For all services requiring preauthorization, all preauthorization criteria must be met for the authorization to be given. Verification of documentation will be conducted upon postpayment review.

In addition, a hospice must demonstrate respect for an individual's rights by ensuring that an informed consent form specifying the type of care and services that may be provided as hospice care during the course of the illness has been obtained for every individual, either from the individual or his or her representative. A representative is defined as a person who is, because of the individual's mental or physical incapacity, authorized in accordance with state law to execute or revoke an election for hospice care or to terminate medical care on behalf of the terminally ill individual.

A determination of the appropriateness of Medicaid payment will be made for the initial certification period as well as each subsequent recertification period for the individual's first 90 days of care. With the exception of instances where the recipient or representative revokes during a previous benefit period, subsequent periods of care do not have to be authorized but shall be certified by the physician, and the documentation of the physician's certification must be maintained by the hospice. See Chapter VI, "Revocation with Subsequent Re-Election," for additional information. The initial date of authorization of services will not be made retroactive prior to the date of the individual's election for hospice services.

The hospice has the responsibility for providing or arranging for all services pertaining to the terminal illness. DMAS will perform utilization review to determine if the services were provided by the appropriate provider and to ensure that the services provided to Medicaid recipients are medically necessary and appropriate. In addition, DMAS will verify that all certification and recertification requirements are met.

Requests received for services older than 12 months will be denied, and reimbursement will not be made. Exceptions to preauthorization requests for services older than 12 months will only be made in accordance with those exceptions applicable to claims payment as identified in Chapter V.

RECONSIDERATION AND APPEALS

If a request for hospice benefits, either for the initial certification or subsequent recertification is denied by DMAS and the provider disagrees with the decision, the provider must follow the reconsideration process. The provider may request reconsideration of the denial by submitting a letter to:

Program Administration Supervisor
Facility and Home-Base Services Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

The letter must be submitted within 30 days of the notice of denial and must be accompanied by information demonstrating why the reimbursement should not be denied.

If the Program Administration Supervisor of the Facility and Home-Based Services Unit upholds the denial, the provider has 30 days from the notice of the denial to appeal the reconsideration decision. A written request for an appeal of the denial must be submitted to the Director of Appeals at the Department of Medical Assistance Services (DMAS).

Send all written appeals to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS upholds the decision to deny reimbursement, the provider may further appeal by requesting a formal evidentiary hearing and submitting a request in writing within 30 days of the notice of the results of the informal fact finding conference. Mail the request to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

CLIENT APPEALS OF THE DENIAL OF SERVICES

Any denial of coverage for a service not yet rendered may be appealed to the Department of Medical Assistance Services. This decision should be appealed in writing by the recipient or his or her legally-appointed representative. All appeals must be filed within 30 days of the date of the final decision notification. Send appeals to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

PAYMENT FOR SERVICES

General Information

Participation in the hospice program requires providers to accept as payment in full the amounts paid by the Medicaid Program plus any applicable copayments. While payments by DMAS may be less than the provider's usual and customary charge, recipients are only responsible for the co-payment.

The basis for payment shall be based on the location of the service rather than the location of the agency. Payment for services will not exceed the amounts indicated to be paid in accordance with the policy and methods described in the Virginia *State Plan for Medical Assistance*. Medicaid reimbursement for hospice care will be made at one of four predetermined rates for each day in which a Medicaid recipient is under the care of the hospice. The rate paid for any particular day would vary depending on the level of care furnished to the recipient.

Payment Methodology

There are four levels of care into which each day of care is classified. For each day that a Medicaid recipient is under the care of a hospice, the hospice will be reimbursed an amount applicable to the type and intensity of medically necessary services furnished to the recipient for that day, as described below:

A. **Routine Home Care** - The hospice will be paid the routine home care rate for each day the recipient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

B. **Continuous Home Care** - The hospice will be paid the continuous home care rate when continuous home care is provided. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of 8 hours must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day. The provider must maintain documentation to justify the number of hours of care that were provided.

C. **Inpatient Respite Care** - The hospice will be paid at the inpatient respite care rate for each day on which the recipient is in an approved inpatient facility and is receiving respite care. Payment for respite care may be made for a maximum of five days at a time including the date of admission but not counting the date of discharge. Payment for the sixth and any subsequent days must be made at the routine home care rate.

D. **General Inpatient Care** - Payment at the inpatient rate will be made when general inpatient care is provided. None of the other fixed payment rates (e.g., routine home care) will be applicable for a day on which the recipient receives hospice inpatient care.

By electing to receive services under the hospice benefit, the recipient waives his or her right to the coverage of services under other Medicaid benefits with the exception of ambulance services. However, when a recipient requires services due to a condition unrelated to the terminal illness, regular Medicaid coverage is available even for persons with a hospice election in place.

Limitation on Payments for Hospice Care

Payments to a hospice for inpatient care are subject to the same limitation on the number of days for inpatient care furnished to Medicare recipients. During the 12-month period beginning November 1 of each year and ending October 31 of the next year, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied once each year, at the end of the hospice's "cap period" (11/1 - 10/31). If it is determined that the inpatient rate should not have been paid, the hospice's payment for these days will be reduced to the home care rate.

Hospice Recipients Residing in Nursing Facilities (NFs) or Intermediate Care Facilities/Mental Retardation (ICFs/MR)

If a hospice recipient is admitted to a nursing facility under the hospice benefit, the UAI (pre-admission screening evaluation) is not required, if the recipient plans to remain under hospice benefits.

Responsibilities of the Hospice for Recipients in NFs or ICFs/MR

Once an individual or his or her responsible party elects the hospice benefit, the individual is considered a hospice recipient. As such, the hospice is responsible for providing for the following activities:

- Skilled services including but not limited to, administration and monitoring of narcotics therapy, wound care, total parenteral nutrition, physical therapy, occupational therapy, and speech/language pathology services for the treatment of the terminal diagnosis and related conditions;
- Care coordination including, but not limited to, arranging routine appointments and transportation to those appointments, ordering and ensuring receipt of specialized equipment and supplies necessary to carry out the established plan of care for the individual, and ensuring timely physician's visits and pharmacy reviews;
- Assessments and care planning by individual disciplines and timely updates;
- Interdisciplinary team care planning and timely updates;
- Utilization review and maintenance of medical records; and
- Submitting claims to DMAS for routine home care for Medicaid-only recipients. Procedure code Z9434 must be billed by the hospice in conjunction with either procedure code Z9430 (routine home care) or Z9431 (continuous home care).

  The hospice will be reimbursed 95 percent of the Medicaid per diem rate for the nursing facility in addition to reimbursement for either routine or continuous home care.

Responsibilities of the Nursing Facility and the ICF/MR

"Room and board" furnished to the hospice recipient by a nursing facility or intermediate care facility for the mentally retarded (ICF/MR) is defined as follows:

- Performance of personal care services including assistance in activities of daily living and in socializing activities;
- Administration of medications;
- Maintaining the cleanliness of a resident's room; and
- Supervising and assisting in the use of durable medical equipment and

prescribed therapies.

The nursing facility or ICF/MR must bill the hospice, not DMAS, for reimbursement that would normally be paid to the facility by DMAS. Hospice recipients in nursing facilities or ICFs/MR have the same responsibility to apply their income to their cost of care as other nursing facility residents. Local Departments of Social Services will send the facility the DMAS-122 form as with any other resident. The facility bills the hospice instead of DMAS, but the facility must deduct the patient-pay amount from the bill it submits to the hospice. The nursing facility and ICF/MR must account for the patient pay for these individuals and provide the hospice with a copy of the current DMAS-122. The hospice must adjust its total charges for HCPCS code Z9434 (percentage of nursing facility per diem). Any patient pay amount cannot be included in the nursing facility charges. The hospice must submit a copy of the current DMAS-122 identifying the patient-pay amount with its invoice when billing for code Z9434.

For those individuals who are eligible for hospice benefits under Medicare and Medicaid, the hospice must bill Medicare. Unless specifically prohibited by statute, the Medicaid Program is the payer of last resort. In these instances (for example, because Medicare only reimburses for nursing facility care when it is provided in a skilled nursing bed), the routine or continuous home care charges would be billed to Medicare, and the hospice would bill Medicaid for the nursing facility charges.

In addition, Medicaid does not make bed-hold payments to any nursing facility when a recipient is in an acute care setting. Any arrangements to hold a bed for a hospice recipient residing in a nursing facility would be made between the hospice and the nursing facility. The recipient and/or his or her family may elect to pay to reserve the bed while the recipient is hospitalized, but they cannot be required to do so. All residents and their families must be informed that the resident has the right to be admitted at the time of the next available vacancy following discharge from the hospital.

Since dually eligible Medicare/Medicaid recipients who qualify for and are admitted to a Medicare skilled bed must dually elect their hospice benefit, Medicaid cannot become the primary payer for Medicare/Medicaid recipients who elect skilled nursing facility placement.

Nursing facilities must continue to complete a Minimum Data Set (MDS) on hospice recipients as required for all nursing facility residents.

When a recipient is at a nursing facility under their hospice election, the nursing facility does not submit a patient intensity rating system (PIRS) form to DMAS on admission or any subsequent nursing facility stays. Documentation is sent by the hospice provider using a DMAS-421A to notify DMAS when a recipient elects their hospice benefit.

If a resident is in a nursing facility which is enrolled as a Medicaid specialized care provider, no payment for hospice services will be made to the hospice provider by DMAS. The nursing facility specialized care provider is responsible for providing all services needed by the resident. If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected and revoked simultaneously under both programs.

ADVANCE DIRECTIVES

All hospice providers participating in the Medicare and Medicaid Programs must provide adult recipients with information regarding an individual's right to make medical care decisions. This includes the right to accept or refuse medical treatment and the right to formulate advance directives.

The term "advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law and relating to the provision of such care when the individual is incapacitated. The law does not prohibit any health care provider (or any agent of such provider) from refusing, as a matter of conscience, to implement an advance directive. Further, the law does not require individuals to execute an advance directive.

Under the law, the hospice must:

- Provide all adult individuals with written information about their rights under State law to make health care decisions, including the right to accept or refuse treatment and the right to execute advance directives, as well as the provider's written policies respecting the implementation of such rights;
- Inform residents about the hospice provider's policy on implementing advance directives;
- Document in the recipient's medical record whether he or she has signed an advance directive;
- Not discriminate against an individual based on whether he or she has executed an advance directive; and
- Provide staff and community education on advance directives.

The hospice must provide written information to adult clients at the time of the initial receipt of hospice care services.